Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
P.O. Box 47857
Olympia WA 98504-7857

Complaint Form

Today's Date: _____

1. Your Information

Name:_____

Address:_____

City: _____ State: _____ Zip:_____

Phone: Work (____)____–_____ Home (____)____–_____

2. Information about the Facility or Health Care Professional

Type of facility or profession:_____

Name of facility or professional: _____

Address: _____

City: _____ State: _____ Zip:_____

3. Resident/Guest/Patient Information

Full Name (if different than above) _____

Date of Birth (of patient, if complaint involves a patient) _____

Date of incident:_____

4. Please describe your complaint in the space below. Include the name, title and phone number of other patients, witnesses or staff members involved in the incident. Email completed form to the Customer Service Center at HSQAComplaintIntake@doh.wa.gov, or fax to 360.236.2626, or mail to:

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Please attach any supporting documentation and additional sheets if necessary.

For Department of Health use only

Reviewed for multiple authority applications: Date _____ Name _____

Routed to: Multi-authority coordinator: _____ date _____
Office _____ date _____
Office _____ date _____
Office _____ date _____